CHAPTER 79A

HEALTH ACCESS NEW JERSEY MANUAL

Division of Medical Assistance and Health Services
Health Access New Jersey Manual
N.J.A.C. 10:79A
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SUBCHAPTER 6. PARTICIPATION REQUIREMENTS FOR ENROLLEES

SUBCHAPTER 1. GENERAL PROVISIONS

10:79A-1.1 Contents of chapter; application

(a) This subchapter sets forth the general provisions of this chapter, including definitions of words and terms used throughout this chapter.

(b) This subchapter applies to all enrollees and participants and other parties interested in, or affected by, the Health Access New Jersey program.

10:79A-1.2 Purpose and authority

(a) The Health Access New Jersey Program provides subsidies for health benefits coverage in order to provide health care for low income, uninsured children, working people, and those temporarily unemployed, based on a sliding income scale with modest copayments.

(b) Pursuant to Reorganization Plan No. 001-1999, issued by Governor Christine Todd Whitman, the authority and administration of the Health Access New Jersey Program was transferred from the Department of Health and Senior Services to the Department of Human Services, effective July 23, 1999.

10:79A-1.3 Definitions

Words and terms used in this chapter and subchapter shall have the meanings as set forth below, unless specifically defined otherwise in another subchapter of this chapter, or the context clearly indicates otherwise.

"Access Program" means the Health Access New Jersey Program.

"Board" means the Individual Health Coverage Program Board of Directors established pursuant to N.J.S.A. 17B:27A-10.

"Carrier" means an insurance company, a health service corporation or health maintenance organization admitted to transact the business of insurance in New Jersey, authorized to do the business of health insurance or provide coverage of health services, and which is issuing standard health benefits plans in accordance with the

Individual Health Coverage Program, pursuant to N.J.S.A. 17B:27A-2 et seq.

"Contribution" means the amount of money which Access Program enrollees must submit to the Access Program towards the cost of purchasing health coverage.

"Credit or dividend" means the sum total of amounts returned to the Access Program and amounts retained by the participating carrier, pursuant to a formula established by the Division of Medical Assistance and Health Services (DMAHS) of the Department of Human Services which are necessary to assure minimum loss ratio standards are met.

"Department" means the Department of Human Services.

"Division" means the Division of Medical Assistance and Health Services of the New Jersey Department of Human Services.

"Enrollee" means a person who has been determined by the Access Program as eligible to receive a subsidy towards the purchase of health coverage, and who has agreed to abide by the rules of the Access Program in obtaining and maintaining such health coverage.

"Health Access New Jersey" means the subsidized insurance program of the Department of Human Services.

"Health care provider" means a person or facility providing health care within the scope of their licensure and includes Federally Qualified Health Centers, approved provider-sites participating in the New Jersey Primary Care Physician and Loan Redemption Program and Community and School-based Clinics.

"Participant" or "participate" means that a carrier has entered into a contract with the Division to provide benefits or covered services to Access Program enrollees subject to the rules of the Access Program.

"Premium" means the total amount billed by a participating carrier for the purchase of a standard health benefits plan by an individual, husband and wife, parent and child(ren) or family.

"Standard health benefits plan" means that plan of health coverage promulgated by the Board referred to as the HMO plan in accordance with N.J.S.A. 17:27A- 7.

"Subsidy" means the amount of money which the Access Program submits towards the cost of purchasing health coverage for an enrollee.

10:79A-1.4 General provisions

(a) The Division shall provide a subsidy for the cost of health coverage for persons who are enrollees of the Access Program.

1. The Access Program subsidy shall not cover the full amount of the cost of the enrollee's health coverage.

2. The amount of subsidy for each enrollee shall be determined by the Division, based upon a consideration of family income, premiums to be charged by participating carriers, the number of current enrollees, and the current level of funding for the Access Program.

3. Subsidy amounts shall decrease as an enrollee's income increases.

(b) No application for enrollment into the Access Program shall be considered if it was received by the program after December 31, 1995.

(c) The Division shall provide a subsidy for the purchase of an individual standard health benefits plan, referred to as the HMO plan, promulgated by the Board and offered by a participating carrier.

(d) No carrier shall become a participating carrier of the Access Program until a completed application form has been submitted to the Division, and the carrier has been determined eligible to be a participant, in accordance with the provisions of this chapter. Submission of a completed application to be a participating carrier shall be deemed by the Division as an agreement by the applicant to abide by the rules of the Access Program if the applicant becomes a participating carrier.

10:79A-1.5 Enforcement and severability

(a) Any person or entity that violates the provisions of this chapter and subchapter shall be subject to all penalties and remedies available under law.

(b) The provisions of this chapter and subchapter shall be enforced by the Departments of Health and Senior Services, Human Services, Banking and Insurance, and the Individual Health Coverage Program Board, as appropriate.

(c) If any provisions of this chapter or subchapter are determined to be inapplicable to any person or circumstances, its applicability to other persons or circumstances shall remain unaffected thereby.

END OF SUBCHAPTER 1

SUBCHAPTER 2. ADMINISTRATION OF THE ACCESS PROGRAM

10:79A-2.1 Purpose and scope

This subchapter sets forth the general functions and administration of the Access Program as authorized by the Department of Human Services, including the coverage which shall be subsidized through the Access Program. The Department may enter into or authorize contracts as necessary to effectuate the administration of the Access Program. The administration of the Access Program shall be the responsibility of the Division of Medical Assistance and Health Services, within the Department of Human Services.

10:79A-2.2 Definitions

Words and terms used in this subchapter shall have the definitions as set forth at N.J.A.C. 10:79A-1.3, or as defined below, unless the context clearly indicates otherwise.

"Base plan" means that benefits plan determined by the Division to have the lowest premium used to calculate the subsidy and the minimum contribution.

"Minimum contribution" means the lowest amount of contribution an enrollee is expected to pay given the base plan available to the enrollee.

"Minimum contribution scales" are the scales established by the Division setting forth, on a county by county basis if necessary, the minimum contribution required for each designated income increment, developed in consideration of the designated base plan(s).

"Rating tier" means rating by single, parent and child(ren), husband and wife, and family.

10:79A-2.3 Benefits package available to enrollees under the Access Program

(a) The Division of Medical Assistance and Health Services shall provide a subsidy to enrollees that purchase from a participating carrier the standard health benefits plan, referred to as the HMO plan, promulgated by the Individual Health Coverage Program

Board in accordance with N.J.A.C. 11:20, subject to the following restrictions:

1. The Division shall subsidize enrollees with income levels which shall not exceed 250 percent of the poverty level as defined at N.J.A.C. 10:79A- 3.3(a) for the purchase of the standard individual health benefits HMO plan established by the Board.

2. The only copayment option which shall be subsidized by the Access Program for the HMO Plan is the $100.00 hospital inpatient copayment and $10.00 copayment for other services option.

3. Enrollees enrolled as of May 15, 2000 in plans other than the HMO Plan shall continue to receive subsidies from the Access Program until such time as they become disenrolled from the program or choose to request a transfer to the HMO Plan.

4. Enrollees enrolled as of May 15, 2000 in the HMO Plan shall not be allowed to transfer into a traditional indemnity plan.

(b) The Division of Medical Assistance and Health Services shall review the appropriateness of the benefits package and shall consider, in its review, whether the benefits package is meeting the health care needs of the population and the administrative requirements of the program.

10:79A-2.4 Functions of participating carriers

(a) Participating carriers' functions with respect to the Access Program shall include, but not be limited to, the following:

1. Provision of benefits or covered services to Access Program enrollees;

2. Collection and submission of data on a periodic basis as required by N.J.A.C. 10:79A-5 and other provisions of this chapter;

3. Collection and submission of data from time to time;

4. Serving as the first level of review of enrollee complaints regarding benefits, covered services, claims payments and general contract administration;

5. Maintenance of claims files, complaint and resolution files, and general correspondence records relating to Access Program enrollees;

6. Provision of notice to the Division of all legal action taken by a carrier against an

Access Program enrollee, or action taken by an Access Program enrollee against a participating carrier;

7. Provision of notice to the Division of any actions taken by a governmental agency, independently or upon the request of the carrier, relevant to the carrier's financial soundness, including, but not limited to, relief requested and relief granted pursuant to N.J.A.C. 11:20-11, or placement of the carrier into conservation, rehabilitation or liquidation pursuant to N.J.S.A. 17B:32-1 et seq., or such similar law in the carrier's state of domicile;

8. Provision of notice to the Division of any substantial restructuring of the carrier or of a new financial arrangement, including, but not limited to, acquisition of or by another carrier, merger with another carrier, or movement of large blocks of business into assumption reinsurance contracts, whether as a ceding or assuming carrier;

9. Timely provision of notice to the Division of an intent to terminate the participation contract as set forth at N.J.A.C. 10:79A-5.7(f);

10. Provision of notice to the Division of changes in the carrier's network, semi-annually or whenever the carrier amends its booklet specifying its participating health care providers, whichever is earlier, if standard health benefits plans are offered under an HMO, except that carriers shall provide notice to the Division of termination of any hospital's contract with the carrier immediately;

11. Provision of notice to the Division of any discrepancies between the Access Program's basis for premium payments and the carrier's basis for premium collection, including for instance, any misunderstanding regarding the number of enrollees covered by a participating carrier; and

12. Submitting periodically to an audit by an independent auditor selected by the Division, at the cost of the carrier, which may include, but not necessarily be limited to: claims handling and payment; complaint handling; and procedures and accounting practices related to premium income, commissions, claim payment and expense allocation.

10:79A-2.5 Administrative functions of the Division of Medical Assistance and Health Services with respect to the Access Program

(a) The administrative duties of the Access Program, for which the Division may contract services, shall include, but not be limited to, the following:

1. Disenrollment of persons in the Access Program, in accordance with N.J.A.C. 10:79A-1.4;

2. Performance of continued eligibility determinations, which may include assets attestation for continued eligibility of enrollees subsequent to each 12 months of enrollment;

3. Maintenance of enrollment files;

4. Performing determinations of subsidy amounts based upon a subsidy formula approved by the Division, in accordance with N.J.A.C. 10:79A-1.4;

5. Collection of enrollee contributions, and matching of contributions with subsidy dollars and, when applicable, credits or dividends and administrative expense allowances;

6. Informing enrollees enrolled as of May 15, 2000, who become disenrolled from the program, of the availability of other insurance programs for which they might be eligible;

7. Notifying carriers in a timely manner of an enrollee's disenrollment;

8. Collection and maintenance of data from participating carriers set forth at N.J.A.C. 10:79A-5, or as otherwise specified by the Division;

9. Preparation of periodic status reports on enrollment, disenrollment and financial status of the Access Program;

10. Preparation of periodic reports based, in whole or in part, upon data collected from the participating carriers;

11. Accounting of the finances of the Access Program using Generally Accepted Accounting Principles;

12. Contracting with the participating carriers, independent auditors, independent actuaries, independent accountants and for other services and supplies as necessary for the proper functioning of the Access Program;

13. Collecting, evaluating and maintaining certain data from participating carriers to monitor the continued well-being and accomplishment of objectives of the Access Program;

14. Monitoring of the Access Program for fraud and abuse by all parties;

15. Establishing of a procedure for handling grievances and appeals by enrollees and carriers, and administration of that process, which shall include maintenance of records of all facets of the grievances and appeals;

16. Approval of participating carriers on an annual basis, in accordance with the provisions of N.J.A.C. 10:79A-5;

17. Amending provisions of the Access Program as necessary, in accordance with the Administrative Procedure Act;

18. Handling of inquiries about the Access Program;

19. Liaison with the Executive Director(s) of the Individual Health Coverage Program and Small Employer Health Benefits Program Boards of Directors and other State departments and government agencies as appropriate; and

20. Establishment of a subsidy and minimum contribution scale.

(b) The Division may establish penalties or other sanctions for carriers and contractors who fail to meet contracted objectives.

10:79A-2.6 Contributions and premiums

(a) Contributions from enrollees shall be collectible by the Access Program 15 days prior to the beginning of each month during which an enrollee will be covered under a subsidized individual standard health benefits plan.

(b) The Division shall submit premiums to participating carriers through the Access Program on a monthly basis, at the beginning of each month.

(c) If it is determined that an enrollee is no longer eligible for the Access Program subsequent to receipt of the billed contribution by the Access Program, coverage shall remain in effect for that enrollee through the end of the month for which the contribution was submitted, with correspondingly appropriate premium remitted by the Access Program to the carrier for that enrollee.

(d) The Access Program shall return any and all contributions submitted by an enrollee more than 30 days following the issuance by the Access Program of a notice of disenrollment to that enrollee.

10:79A-2.7 Contribution and subsidy

(a) The minimum contribution an enrollee shall be required to pay to the Access Program shall be based upon a minimum contribution scale.

1. The minimum contributions shall increase as income levels increase.

2. The minimum contribution to income ratios may not necessarily be proportional.

3. Each enrollee shall be required to pay a minimum contribution, as determined by the Division.

(b) An enrollee's minimum contribution may be recalculated whenever the minimum contribution scale is recalculated, or more frequently if a change in the enrollee's circumstances results in a change in the enrollee's income level relative to the incremental income levels contained in the minimum contribution scale.

(c) The total subsidy the Access Program shall submit on behalf of an enrollee shall be based upon the difference between the enrollee's minimum contribution and the premium of the base plan. The subsidy shall be recalculated at least annually.

1. If not all standard health benefits plans to be subsidized by the Access Program are available Statewide, then the base plan may vary on a county by county basis.

2. The base plan may vary for each rating tier.

(d) An enrollee may elect to purchase a standard health benefits plan with a higher premium than the premium of the base plan, but in doing so, the enrollee shall be responsible for submitting contributions equal to the difference of the premium not covered by the subsidy and the minimum contribution requirement of that enrollee.

(e) An enrollee may change HMO carriers, subject to the limitations imposed at N.J.A.C. 10:79A-2.3, consistent with the rules promulgated by the Board at N.J.A.C. 11:20.

(f) The Access Program shall provide enrollees with 30 days prior written notice of any changes in contribution requirements due to premium changes for the plan purchased by the enrollee.

10:79A-2.8 Notices

All notices shall be deemed properly sent if sent by regular United States Postal Service to the most recent address on record with the Access Program.

10:79A-2.9 Administrative expenses

(a) The Division shall calculate the projected administrative expenses of the Access Program for the ensuing year of the Access Program prior to the beginning of each year.

(b) The Division shall allocate the projected administrative expenses between the participating carriers and the Division. The administrative expenses of the program shall be allocated 50 percent to the Division and 50 percent to the participating carriers.

1. Administrative expenses chargeable to participating carriers shall be allocated according to each carrier's market share.

2. Administrative expenses, as contracted between participating carriers and the Division, for services performed by the Access Program on behalf of the participating carriers, shall include:

i. Expenses related to determining subsidy and minimum contribution levels, redeterminations of eligibility and subsidy, notification and processing of terminations and disenrollment;

ii. Expenses related to billing, collection, and general fund maintenance;

iii. Expenses related to contracted independent professional services provided to the Access Program, including actuarial, accounting and auditing services; and

iv. Expenses related to audits, specified by the Division, of the various aspects of the Access Program, except that the expenses of an independent audit of a specific participating carrier shall be the sole responsibility of the specific participating carrier.

(c) The Division shall charge the projected administrative expense to participating carriers as interim calendar year administrative expenses and may do so on a monthly basis.

(d) The Division may remit monthly premiums offset by administrative expense receivables from a participating carrier.

(e) Following the close of each fiscal year, the Division shall determine the actual incurred calendar year administrative expense, allocating the actual incurred calendar year administrative expense as specified in (b)2 above.

10:79A-2.10 Billing of enrollees and declarations of status

(a) The Division shall bill enrollees on a monthly basis, as follows:

1. Enrollees shall be billed 30 days prior to the due date of the contribution payment; and

2. Contributions shall be due and payable 15 days prior to the first day of each month, except as N.J.A.C. 10:79A-2.6 applies.

(b) The Division shall not remit a premium payment on behalf of an enrollee until the full amount of the enrollee's billed contribution then due and payable is received.

1. The Division shall notify an enrollee within 10 days following the date any unpaid contribution was due and payable that failure to remit the full amount of the contribution within 30 days following the date the contribution was due and payable shall result in disenrollment of the enrollee from the Access Program. The notice shall contain the following information:

i. A statement that failure to submit the contribution shall result in the Access Program not remitting a premium on behalf of the enrollee to the participating carrier;

ii. A statement of the final date upon which the Access Program will accept a late payment of the full contribution and agree to remit the premium payment to the participating carrier on behalf of an enrollee;

iii. A statement that if the enrollee fails to submit the full contribution within 30 days following the date the contribution was due and payable, the enrollee may remit the full amount of the premium owed directly to the participating carrier during an additional 16 day grace period and maintain the coverage in force, even though no longer an Access Program enrollee;

iv. A statement setting forth the full premium that will be owed by the enrollee to maintain the coverage in force if the enrollee is disenrolled from the Access Program; and

v. A statement that the enrollee has the right to appeal the disenrollment decision pursuant to N.J.A.C. 10:79A-2.11.

2. The Division shall, within 20 days following the date that any unpaid contribution was due and payable, provide a second notice to the enrollee setting forth all of the information of (b)1 above.

3. The Division shall provide notice to an enrollee that disenrollment for nonpayment of contribution is effective, and shall include in the notice the information specified in (b)1iii through v above.

(c) Monthly billings shall include a requirement that enrollees indicate any change in status pursuant to N.J.A.C. 10:79A-3.5(c). Receipt of the monthly contribution shall be deemed an affirmation that status remains unchanged. Failure to report a change in status pursuant to N.J.A.C. 10:79A-3.5(c) may result in disenrollment from the Access Program.

(d) The Division shall, if necessary, request additional explanation and appropriate documentation from an enrollee upon receipt of a declaration of a change in status, as change in status is specified at N.J.A.C. 10:79A- 3.5(c), to determine whether a redetermination of the enrollee's eligibility or subsidy is required. If a redetermination is necessary, the Commission shall continue to bill enrollees on the appropriate then-current contribution basis, until the redetermination is completed.

(e) The Division may perform exit surveys of enrollees whether the enrollee is disenrolled involuntarily or initiates disenrollment through an affirmative statement of intent to terminate enrollment in the Access Program.

10:79A-2.11 Grievances and appeals

(a) If an enrollee has a grievance pertaining to the subsidy level calculated or involuntary disenrollment in the Access Program, the enrollee shall submit a description of the grievance to the Access Program in writing within 10 days of the adverse notification. The Access Program shall notify the enrollee of its decision on the matter in writing, specifying the reasons for the decision, within 30 days of receipt of the complete documentation of the grievance. The Access Program shall retain all correspondence and documentation relating to the grievance in the enrollee's file. The Access Program's decision shall be considered the final agency determination.

(b) Grievances relating to the provision of benefits or services under the standard health benefits plans are appealable to the carrier, the Board or the Commissioner of Banking and Insurance, as appropriate.

END OF SUBCHAPTER 2

SUBCHAPTER 3. ELIGIBILITY CRITERIA

10:79A-3.1 Purpose and scope

This subchapter establishes the eligibility criteria that all individuals and families shall meet in order to remain enrolled in Health Access New Jersey.

10:79A-3.2 Definitions

Words and terms as used in this subchapter shall have the definitions as set forth at N.J.A.C. 10:79A-1.3, or as defined below, unless the context clearly indicates otherwise.

"Gross income" means total wages earned before taxes and deductions, and includes tips, royalties, supplemental security income, veteran's administration benefits, unemployment benefits, worker's compensation benefits, income from public assistance programs, child support, spousal maintenance or support payments, dividend and interest income, pensions, social security, net gambling and lottery winnings, and income from other sources.

10:79A-3.3 Eligibility criteria for Health Access New Jersey

(a) An enrollee shall remain eligible for the Access Program if:

1. The enrollee meets the eligibility limits established by the Division at (a)2 through 5 below, and the applicant's family gross income meets the income limits established by the Division, which shall not exceed 250 percent of the Federal poverty income guidelines revised annually by the United States Department of Health and Human Services, pursuant to the provisions of 42 U.S.C. § 9902(2), incorporated herein by reference. (For further information on the poverty income guidelines, contact the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, DC 20201; telephone: 202-690-6141);

2. The enrollee continues to reside in New Jersey, with the intent to remain for the majority of the year;

i. All enrollees shall be required to submit a signed affidavit stating their intent to

remain in New Jersey for the majority of the year; and

ii. Documentation of residency may be required, if determined necessary by program audit staff.

3. The enrollee is not eligible for employer-based insurance.

4. The enrollee is not currently enrolled in any other government program providing health care benefits; and

5. The enrollee is not currently covered under an individual standard health benefits plan or other individual health coverage (other than limited benefit policies).

(b) An enrollee's eligibility shall be redetermined on at least an annual basis, and in each subsequent 12 month period an enrollee shall submit an attestation of assets in addition to submitting to a redetermination of eligibility based on gross income.

10:79A-3.4 Determination of income

(a) Gross income for the person to be insured shall include the gross income of all legally responsible adults in a family, unearned income of minor children, and with respect to dependents of persons residing in a household separate from the dependent, that portion of the legally responsible adult's income required to be available for the care and support of that dependent.

1. A family includes legally married spouses and their dependent child(ren), and a single person and his or her dependent child(ren), as child and dependent are defined by the Board in the standard health benefits plan HMO policy form in Exhibit F of the Appendix to N.J.A.C. 11:20.

2. A family shall not include persons residing within the same residence who do not have a legal relationship or legal dependency obligation for support.

(b) Income for purposes of determining eligibility for the Access Program shall be determined as follows:

1. For farm and nonfarm self-employed persons, income shall be calculated using adjusted gross income reported on the family's Federal income tax form(s) from the prior year as the baseline and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged. Enrollees shall report the most recent financial situation of the family if it has

changed from the period of time covered by the Federal income tax form. The report may be in the form of a percentage increase or decrease.

2. For wage earners, income shall be calculated based on gross income reported in the four months immediately preceding, multiplied by three to reflect a 12 month period.

3. For unemployed persons eligible for a governmental income program, income shall be determined by the amount of expected payments from the government agency plus any other gross income.

4. For other individual circumstances, income shall be calculated based on a combination and/or variation of (b)1, 2, and/or 3 above, as appropriate.

10:79A-3.5 Proof of income and other eligibility requirements

(a) The enrollee shall provide acceptable proof of income that may include any of the following: pay check stub, W-2 form, a letter from an employer on company letterhead stating an individual's income, or a statement of the gross benefit amount from any governmental agency providing benefit to the individual. These should be submitted in the combination appropriate for the individual or family. Enrollees shall submit a signed copy of their most recent Federal income tax form filed, if any.

(b) Additional documentation may be requested of an individual, on a case-by- case basis, for verifying eligibility in the Access Program.

(c) Changes that could impact an individual's or family's eligibility for the Access Program shall be reported immediately. As soon as identified, enrollees shall report, at a minimum, changes in the following:

1. Income;

2. Employment status;

3. Family composition (birth, death, marriage, divorce);

4. Address; and

5. Availability of other health coverage.

(d) Failure to provide factual information may result in immediate disenrollment from the Access Program and may result in the imposition of payback provisions available under

the law.

END OF SUBCHAPTER 3

SUBCHAPTER 4. ELIGIBILITY REDETERMINATION, AUDIT AND DISENROLLMENT PROCESSES

10:79A-4.1 Purpose and scope

This subchapter establishes the eligibility redetermination, audit and disenrollment processes for the Health Access New Jersey subsidized insurance program.

10:79A-4.2 Definitions

Words and terms used in this subchapter shall have the definitions as set forth at N.J.A.C. 10:79A-1.3, unless the context clearly indicates otherwise.

10:79A-4.3 Redetermination and audit

(a) The Access Program may request information more frequently than annually from an enrollee for the purpose of verifying eligibility if there is good cause to believe that the enrollee's income, residency, family size or other eligibility criteria may have changed since the date on which information was last received by the Access Program. Enrollees shall be given at least 20 days from the date of any such information request to respond to the request. Each enrollee shall be responsible for notifying the Access Program within 30 days of any changes which could affect the enrollee's eligibility or income level.

(b) The Division may authorize random audits to verify reported income and eligibility and may execute data sharing arrangements with other governmental agencies in order to perform income verification.

(c) Information specific to an enrollee or former enrollee obtained through an audit shall remain confidential, but such information shall be used as necessary for the Access Program and other governmental agencies to carry out the operations of the respective agency, and such information shall be subject to release upon court order. The Access Program and other agencies may use the data gathered to prepare reports for external use so long as the information is not presented in a manner that identifies any specific enrollee or former enrollee.

10:79A-4.4 Disenrollment from the Access Program

(a) An enrollee may disenroll effective the first day of any month by giving the Access Program at least 15 days prior written notice of the intention to disenroll. The Division shall establish procedures for notice by an enrollee of a disenrollment decision, including the date upon which disenrollment shall become effective.

1. Nonpayment of premium contribution by an enrollee shall be considered an indication of the enrollee's intention to disenroll from the plan. The enrollee's Access Program eligibility shall remain effective through the grace period specified at N.J.A.C. 10:79A-2.10(b).

2. An enrollee's coverage by a participating carrier shall be subject to the terms of the grace provision contained in the standard health benefits plan contract, and the enrollee shall have the opportunity to maintain coverage under the standard health benefits plan following disenrollment from the Access Program if the enrollee submits the full amount of the premium owed directly to the carrier.

(b) The Access Program may disenroll any enrollee from the Access Program for good cause, which shall include: failure to meet the eligibility requirements set forth in N.J.A.C. 10:79A-3.3; loss of eligibility; nonpayment of premium contribution; and fraud or abuse. The Access Program shall provide the enrollee with advance written notice of its intent to disenroll the enrollee specifying the reasons for the disenrollment action. Such notice shall specify an effective date of the notice, and shall describe procedures for disenrollment, including the enrollees's right to appeal the disenrollment decision pursuant to N.J.A.C. 10:79A-2.11.

End OF SUBCHAPTER 4

SUBCHAPTER 5. PARTICIPATION REQUIREMENTS FOR CARRIERS

10:79A-5.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the terms under which carriers may participate in the Health Access New Jersey program.

(b) This subchapter sets forth the standards required for a carrier's initial participation and continued participation in the Access Program.

(c) This subchapter sets forth the process of orderly withdrawal of a carrier from participation in the Access Program.

10:79A-5.2 Definitions

Words and terms used in this subchapter shall have the definitions set forth at N.J.A.C. 10:79A-1.3 and as further defined below, unless the context clearly indicates otherwise.

"Actual claims incurred loss ratio" means the ratio of actual claims incurred under the Access Program divided by the earned premium under the Access Program (before administrative expenses are paid to the Division).

"Clean claim" means a claim that has no defect (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

"Relief" means a waiver from acceptance of applications as required by the Individual Health Coverage Program or a deferment of payment of assessment obligations under the Individual Health Coverage Program as permitted by N.J.S.A. 17B:27A-8 and 17B:27A-12, respectively, which relief must be applied for and approved by the Commissioner of Insurance.

"Selective contracting arrangement" means an arrangement, approved pursuant to N.J.A.C. 11:4-37, for the payment of benefits for covered services by the carrier to preferred providers or preferred provider organizations, which establishes predetermined fee or reimbursement levels.

10:79A-5.3 General provisions

(a) Any carrier that submits a completed application in accordance with N.J.A.C. 10:79A-5.5 shall be deemed to have agreed to the standards for initial participation set forth at N.J.A.C. 10:79A-5.4 and the standards for continued participation set forth at N.J.A.C. 10:79A-5.7, if determined by the Division eligible to be a participating carrier.

(b) Eligibility to participate may be subject to annual review by the Division.

(c) The Division may limit the number of carriers participating in the Access Program, based upon the needs of the Access Program, regarding enrollment and administrative requirements.

10:79A-5.4 Standards for participation

(a) Carriers currently shall offer standard health benefits plans in accordance with N.J.S.A. 17B:27A-2 et seq. and rules promulgated thereunder.

1. No carrier seeking to participate shall have sought relief in the 12 consecutive calendar months preceding the date of its application to participate.

2. A carrier which has obtained relief at any time shall have been offering standard health benefits plans without any relief for no less than 12 consecutive calendar months preceding the date of its application to participate.

(b) A carrier shall offer to Access Program enrollees the same standard health benefits HMO Plan, subject to the limitations imposed at N.J.A.C. 10:79A- 2.3, that it offers to all eligible persons (as defined at N.J.A.C. 11:20- 1.2), who are not Access Program enrollees.

(c) Carriers shall accept all premium payments from the Access Program as payment in full for those standard health benefits plan contracts delivered to Access Program enrollees.

(d) Carriers shall agree to provide coverage to Access Program enrollees until such time as the Access Program provides notice to the carrier of the effective date of the enrollee's disenrollment (subject to any grace provisions contained in the enrollee's standard health benefits plan contract with the carrier) and in accordance with N.J.A.C. 10:79A-5.9.

(e) Carriers shall agree to accept payment of the premium net of amounts owed by the carriers to the Access Program with respect to at least the following:

1. The administrative costs of the Access Program chargeable to the carriers as set forth at N.J.A.C. 10:79A-5.11;

2. Credits for premium collected from the Access Program, as a result of a loss ratio less than 75 percent as required by N.J.S.A. 17B:27A-9, if any; and

3. Credits for premium collected from the Access Program which resulted in a loss ratio exceeding 75 percent but which is less than 85 percent, pursuant to a formula set forth at N.J.A.C. 10:79A-5.10, if any.

(f) Carriers shall provide data to the Access Program from time to time as specified by the Division.

(g) Carriers offering standard health benefits plans through an HMO or subject to a selective contracting arrangement are encouraged to build networks in under-served areas including consideration of contracting with Federally Qualified Health Centers and/or approved provider sites participating in the New Jersey Primary Care Physician and Dentist Loan Redemption Program and/or Community and School-based Clinics.

(h) Carriers offering standard health benefits plans through an HMO or subject to a selective contracting arrangement shall include as part of the network agreement a prohibition on all balance billing for covered services, exclusive of deductibles, coinsurance and/or copayment requirements by network providers, including hospitals.

(i) Carriers shall agree to accept the date of the enrollee's application for eligibility in the Access Program as the date of application for coverage with the carrier for purposes of determining when a gap in coverage exists as that determination relates to the application of preexisting condition exclusions and the crediting of preexisting condition exclusion provisions previously satisfied. Coverage under Medicaid or NJ KidCare shall be considered coverage under a health benefits plan.

(j) Carriers shall agree that the effective date of coverage for an enrollee shall be the date specified by the Division, subject to remittance of the full amount of the appropriate premium by the Access Program to the carrier necessary to effect the coverage on the date specified.

(k) Carriers shall provide the Access Program with 45 days prior notice of a change in premium rates.

(l) Carriers shall provide that the premium for an enrollee shall not be amended for a 12 month period following the date of issue of a policy or contract to that enrollee, so long as there is no material change in the provisions of the policy or contract required under law prior to the date of its renewal, or a change in the number of persons covered under the enrollee's contract causing the enrollee's rating tier category to change.

10:79A-5.5 Application to participate

(a) Carriers shall submit a completed application in accordance with N.J.A.C. 10:79A-5.4(a) through (l) to participate to the Division.

(b) The application to participate shall be supported by a copy of the letter from the Board accepting the carrier's certification of use of the Board's standard health benefits plans, or certification of substantial compliance with the Board's standard health benefits plans, as specified at N.J.A.C. 11:20- 3.2.

(c) If the carrier is an HMO, or is offering the standard health benefits plans in conjunction with a selective contracting arrangement, the carrier shall specify the geographic areas in which it is authorized to conduct such business, and shall include its list of providers by medical specialty and office zip codes.

(d) The application to participate shall be accompanied by premium rates for the carrier's standard health benefits plan which it offers currently, as are appropriate to the Access Program (that is, the HMO Plan with the $10.00 copayment option).

(e) The Division may request such additional information as it determines is necessary to fully consider the application to participate, including marketing material, policy forms, and other filings made by the carrier in accordance with N.J.A.C. 11:20-6, 7, 8 and 9.

(f) An application to participate shall not be considered complete until all required information, including information requested by the Division pursuant to (e) above, has been received.

10:79A-5.6 Review of the application to participate

(a) Within 30 days of receipt of the application to participate, the Division shall determine if the application is complete.

(b) If the Division determines that the application to participate is incomplete, the Division shall notify the applicant in writing, specifying the deficiency(ies) or additional information requested pursuant to N.J.A.C. 10:79A-5.5(e). The applicant shall be permitted to cure the deficiency or submit the additional information within 30 days of the date of the notice. If the applicant fails to cure the deficiency within 30 days, the Division shall disapprove the application to participate.

(c) If the Division determines that an application to participate is complete, and that the carrier meets the standards of N.J.A.C. 10:79A-5.4, the application to participate shall be approved.

(d) An applicant that has been disapproved to become a participant may, within 20 days of the date of notice of the disapproval, file a request for a hearing with the Division, consistent with the appeals process at N.J.A.C. 10:49- 10.3.

10:79A-5.7 Standards for continued participation

(a) A participating carrier's contract with the Division shall be reviewed annually, and may be subject to an annual audit, but shall be renewed by the Access Program unless one or more of the following occur:

1. The Division determines that the needs of the Access Program in the areas of enrollment and administration require discontinuance of the carrier's participation;

2. The carrier has failed to comply with all of the requirements of N.J.A.C. 10:79A-5.4;

3. The carrier has an annual enrollee complaint ratio exceeding five percent;

4. The carrier has failed to pay on an annual basis 95 percent of all incurred and reported clean claims within 30 days of submission;

5. The carrier fails to submit a completed annual participant survey as required by (b) below;

6. The carrier seeks relief pursuant to N.J.A.C. 11:20-11;

7. The carrier is placed under an order of conservation, rehabilitation or liquidation pursuant to N.J.S.A. 17B:32-1 et seq.;

8. The carrier's authority to transact the business of providing health insurance, services or benefits in the State of New Jersey is suspended or revoked by the Commissioner of Banking and Insurance;

9. The carrier cedes more than 10 percent of its business under its standard health benefits plans whether through a reinsurance agreement or assumption agreement; or

10. The Division has evidence of fraudulent activity by the carrier against the Access Program.

(b) Within 90 days prior to a participating carrier's anniversary date in the Access Program, the carrier shall submit to the Division an annual participant survey, which shall include, but not necessarily be limited to: information about handling of claims and complaints, the status of health care provider networks, if any, utilized by the carrier, and the participating carrier's financial condition.

(c) Within 60 days prior to a participating carrier's anniversary date in the Access Program, the Division shall determine whether the participating carrier's continued participation is appropriate. If the Division disapproves the carrier's continued participation, the Division shall so notify the carrier in writing, explaining the reasons for the disapproval. The reasons for the disapproval shall be as set forth in (a) above.

(d) The Division shall cancel a carrier's contract to participate subject to written notice of no less than 90 days, specifying the reasons for the cancellation of the contract, as set forth in (a) above.

(e) If the Division disapproves the continued participation of a carrier at any time, the carrier shall have the right to request a hearing from the Division within 20 days of the date of notice that the carrier's contract will be canceled or nonrenewed.

1. From the date the carrier's contract is cancelled or nonrenewed until the final determination of the hearing, the carrier shall not accept new enrollees (other than family members of a current enrollee) upon the basis of being a participating carrier through which the enrollee will be able to obtain a subsidized standard health benefits plan.

2. The carrier shall continue to renew Access Program enrollees' standard health benefits plan contracts pursuant to N.J.A.C. 10:79A-5.9.

(f) A participating carrier may elect to terminate its contract with the Access Program by providing no less than 180 days notice of its intent to terminate the contract, subject to the following restrictions:

1. Until the date that the carrier's contract will terminate, the carrier shall continue to accept Access Program transfers on the basis of the carrier being a participating carrier through which the enrollee will be able to obtain a subsidized standard health benefits plan;

2. Notwithstanding (f)1 above, if a carrier is the only participating carrier in a county, it shall continue to accept Access Program transfers as a participating carrier in that county until the Access Program contracts with another carrier in that county; and

3. The carrier shall continue to renew Access Program enrollees' standard health benefits plan contracts pursuant to N.J.A.C. 10:79A-5.9.

10:79A-5.8 Relief

(a) A carrier shall notify the Division that it is seeking relief from the Commissioner of Banking and Insurance pursuant to N.J.A.C. 11:20-11. Notice of the carrier's decision to seek relief shall be provided concurrent with its notice to the Commissioner of Banking and Insurance.

(b) Notice of the carrier's intent to seek relief shall constitute notice by the carrier of its intent to terminate its contract with the Access Program, and the carrier shall comply with N.J.A.C. 10:79A-5.7(f), notwithstanding a grant of its relief, in the case of a waiver of obligations, by the Commissioner of Banking and Insurance.

10:79A-5.9 Renewal of enrollees

(a) Carriers shall renew Access Program enrollee standard health benefits plan contracts upon their anniversary dates, subject to the provisions of N.J.S.A. 17B:27A-6.

(b) If the Access Program indicates that an enrollee is no longer eligible for subsidy, the enrollee's standard health benefits plan contract shall be continued or renewed without the Access Program subsidy at the option of the enrollee.

(c) If a carrier's contract with the Access Program is being terminated, at least 60 days prior to each enrollee's anniversary date, the carrier shall provide notice to the enrollee that the carrier is no longer participating in the Access Program, and that in order for the enrollee to continue to receive subsidization of his or her standard health benefits plan contract, the enrollee will have to obtain coverage from another carrier that is participating in the Access Program. Such notice shall direct the enrollee to contact the Access Program to obtain information about other participating carriers.

(d) If a carrier's contract with the Access Program is being terminated, standard health benefits plan contracts of Access Program enrollees shall remain in force until the enrollee's first anniversary date following the date of termination of the participating carrier's contract, the date the enrollee terminates coverage, or the enrollee is disenrolled by the Access Program, whichever date is earlier.

1. The carrier shall offer to continue or renew the enrollee's contract without the subsidy at the option of the enrollee.

2. The Access Program shall continue to provide subsidy for the purchase of enrollees' standard health benefits plan contracts with the terminating carrier until the enrollee is disenrolled or until its anniversary date, whichever date is earlier, notwithstanding termination of the carrier's contract.

3. Carriers shall continue to accept payment of premiums from the Access Program net of amounts owed by carriers to the Access Program as set forth in N.J.A.C. 10:79A-5.4(d), so long as Access Program enrollees continue to obtain subsidized coverage with a carrier.

10:79A-5.10 Loss ratio reports and credit formula

(a) No later than August 15 annually, each carrier shall submit to the Department of Banking and Insurance a loss ratio report for the preceding calendar year.

1. Within 30 days following receipt of a participating carriers' report, the Department of Banking and Insurance will notify the carrier in writing if the report is incomplete.

2. Within 30 days following the receipt of a notice that the report is incomplete, the carrier shall cure the deficiency.

3. If a carrier fails to cure a deficiency within 30 days, the Department of Banking and Insurance will notify the Division and the Division may treat such a failure as effective notice of the carrier's intent to terminate its contract with the Access Program pursuant to N.J.A.C. 10:79A-5.7(f).

4. If a carrier fails to cure a deficiency within 30 days, the Department of Banking and Insurance will calculate the missing information based upon information submitted by other participating carriers, and shall interpret such information in a manner most favorable to the Access Program.

5. The Department of Banking and Insurance will notify the Division of Medical Assistance and Health Services upon completion of any investigation so that the Division can take appropriate action regarding the individual carrier.

(b) No later than 30 days following receipt of a completed loss ratio report from a participating carrier which evidences a loss ratio of less than 85 percent, the Access Program shall submit premium payments to the carrier net of a credit to the Access Program of the amount of premium collected by the carrier which resulted in a loss ratio less than 85 percent, subject to the credit formula set forth at (e) below.

(c) If a carrier ceases to be a participating carrier, and the credit it owes to the Access Program exceeds the amount of premium the Access Program will continue to pay to the carrier until all Access Program enrollees covered by that carrier are disenrolled or obtain coverage with another participating carrier, the carrier shall refund the difference to the Access Program no later than the final date of coverage of the last Access Program enrollee covered by the carrier.

(d) Carriers shall specify in the loss ratio report, a dividend or credit against future premiums for policy forms under which Access Program enrollees are covered as is necessary to assure that the aggregate claims incurred in the previous calendar year plus the amount of the dividend or credit equals 85 percent of the aggregate premiums collected for those policy forms in the previous calendar year.

(e) Carriers shall pay to the Access Program a portion of the dividend or credit amount specified in (d) above, as follows:

1. 0.75 (.85--actual claims incurred loss ratio) x premium collected from the Access Program, plus

2. 0.15 (.80--actual claims incurred loss ratio) x premium collected from the Access Program, plus

3. Such amounts as required for the carrier to be in compliance with N.J.S.A. 17B:27A-9 and rules promulgated thereunder;

4. In no event shall the actual claims incurred loss ratio for (e)1 and 2 above be less than 75 percent; and

5. In no event shall the product calculated in (e)1 or 2 above be less than zero.

10:79A-5.11 Administrative expenses of the Access Program

(a) Certain administrative expenses of the Access Program, as specified at N.J.A.C. 10:79A-2.9, shall be charged to participating carriers. Administrative expenses charged to participating carriers shall be paid by the participating carrier within 30 days of the date of the invoice for the charge.

(b) If the determination of the actual incurred calendar year administrative expenses is less than the determination of interim administrative expenses, the excess administrative expenses charged shall be returned to carriers as follows:

1. If the carrier continues to be a participating carrier, the amount of excess administrative expenses charged to the carrier shall be credited to the immediate subsequent years' administrative expense charge allocable to the carrier.

2. If the carrier's participating carrier contract is terminated, the amount of excess administrative expenses charged to the carrier will be credited against the immediate subsequent year's administrative expense charge as long as Access Program enrollees continue to be covered under subsidized contracts with the carrier, with the remainder of the excess administrative expenses, if any, to be refunded in a lump sum to the carrier thereafter.

(c) If the determination of actual incurred calendar year administrative expenses is greater than the determination of interim administrative expenses for that calendar year, an additional administrative expense charge shall be allocated and charged to that calendar year's participating carriers.

END OF SUBCHAPTER 5

SUBCHAPTER 6. PARTICIPATION REQUIREMENTS FOR ENROLLEES

10:79A-6.1 Purpose and scope

This subchapter sets forth the requirements for continued participation by persons eligible for the Access Program.

10:79A-6.2 Definitions

Words and terms used in this subchapter shall have the definitions as set forth at N.J.A.C. 10:79A-1.3, unless the context clearly indicates otherwise.

10:79A-6.3 General provisions

(a) Enrollees in the Access Program shall agree to the conditions set forth in (b) through (i) below as a condition of continued enrollment in the Access Program. Failure to do so may result in disenrollment from the Access Program, cancellation of coverage by the participating carrier, liability of premiums paid on behalf of the enrollee, and/or full responsibility of the costs of health care services provided to the enrollee.

(b) Eligible enrollees shall submit contributions, as billed, in full to the Access Program by the date specified on the bill received.

(c) Eligible enrollees shall submit to periodic random audits of their family income and assets, except that no enrollee shall be subject to more than two such audits in any calendar year.

(d) Eligible enrollees shall abide by the requirements of the standard health benefit plan form purchased by the enrollee and subsidized by the Access Program.

(e) Eligible enrollees shall notify the Access Program within 30 days of any change in the enrollee's status, as change in status is specified at N.J.A.C. 10:79A-3.5(c).

(f) Eligible enrollees shall notify the Access program within 30 days of any change in the enrollees' eligibility for coverage under an employer's group health benefits plan or as soon as reasonably possible following the date the enrollees become aware of the

change in eligibility.

(g) Eligible enrollees shall agree that the Access Program has a right of subrogation to any dividend or credit against future premium required by carriers to be issued to assure that the aggregate benefits paid plus the dividend or credit equals at least 75 percent of the premium collected in a calendar year for each policy form pursuant to N.J.S.A. 17B:27A-9, up to the full amount of subsidy paid by the Access Program for the separate enrollees in the calendar year for which the dividend or credit is issued.

(h) Eligible enrollees shall agree that the enrollee's right is subordinate to that of the Access Program with respect to receipt of dividends or credits against future premiums required to be issued by carriers pursuant to N.J.A.C. 10:79A-5.11, up to the full amount of subsidy paid by the Access Program for the separate enrollees in the calendar year for which the dividend or credit is issued.

(i) Enrollees who are subsidized for 12 calendar months shall submit to a new eligibility test evaluating income and assets 60 days prior to the end of the 12 calendar month period, if the enrollee continues to claim eligibility for the Access Program.

10:79A-6.4 Continued participation

(a) No enrollee shall be subsidized by the Access Program for more than a 12 month period without reconsideration. All such enrollees shall reapply to the Access Program 60 days prior to the end of the 12 calendar month period if the enrollee is to be considered for further Access Program eligibility. Redetermination packages shall be mailed 90 days prior to the anniversary date. Enrollees shall have 20 days to return the redetermination package. Enrollees who do not respond within 20 days shall be sent a Final Notice letter giving them 10 additional days to respond. Enrollees who do not respond to the Final Notice letter shall be disenrolled on their anniversary date. Enrollees shall have 10 days to respond to requests for missing information. Enrollees who do not respond to requests for missing information shall be disenrolled on their anniversary date.

1. The enrollees' responses shall be postmarked no later than the due dates indicated on the package or letter, or the account shall be disenrolled on the anniversary date.

(b) No enrollee shall be subsidized by the Access Program for more than 30 days following the date an enrollee becomes eligible for an employment-based group health benefits plan. For purposes of this provision, the date from which an enrollee shall be determined eligible for the group health benefits plan shall be the date that the

enrollee's coverage under the group health benefits plan becomes effective.

(c) No enrollee shall be subsidized by the Access Program for more than 30 days following the date an enrollee's health benefits under another government program becomes effective.